STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155139	A. BUILDING 01 B. WING	02/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH WOODS VILLAGE	2233 W JEFFERSON ST KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/11/13 Facility Number: 000064 Provider Number: 155139 AIM Number: 100288770 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, North Woods Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The resident rooms have battery powered smoke detection. The facility has a	K0000	February 28, 2013 Ms. Kim Rhoades, Director Indiana State Department of Health 2 North Meridian St. Indianapolis, Indiana 46204 Dear Ms. Rhoades: Please accept this 2567 Plan of Correction for the Life Safety Code Survey ending 2-11-13, as our Letter of Credible Allegation. Thank you for your time in reviewing our plan of correction and please call with any questions. Sincerely, Cathy S. Greene Executive Director North Woods Village The creation and submission of this plan of correction does not constitute an admission by this provider of any; conclusion set forth in the statement of deficiencies or of any violation of regulation. This provider respectfully request that the 2567 plan of correction be considered the letter of credible allegation and request a post certification review on or after 3-13-13.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	capacity of 164 and had a census of 148 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas which provide facility services were sprinklered except for the two detached garages for facility storage and a shed. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/18/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 2 of 9 smoke barrier walls were protected to maintain the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire be protected, so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 24 residents on second floor north and 36 residents on second floor, south halls as well as visitors and staff if smoke from a fire were to infiltrate the protective barrier wall. Findings include: Based on observations on 02/11/13 at	K0025	February 28, 2013 Ms. Kim Rhoades, Director Indiana State Department of Health 2 North Meridian St. Indianapolis, Indiana 46204 Dear Ms. Rhoades: Please accept this 2567 Plan of Correction for the Life Safety Code Survey ending 2-11-13, as our Letter of Credible Allegation.	03/13/2013

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	2:50 p.m. with the Maintenance Supervisor, at the second story, north smoke barrier wall above the ceiling panels there was a six inch by four inch gap on the left side of a heating/air conditioning supply line which penetrated the smoke barrier to the right of center of the wall. Also, there was a one inch diameter opening around a pipe penetrating the wall on the far left side of the north smoke barrier wall. Furthermore at the second floor, south smoke barrier wall there was a two and one half inch diameter plastic conduit used to funnel fifteen cable wires through the smoke barrier wall, however, only half the pipe opening was filled with wires the remaining one inch and one quarter opening was not filled with a fire rated material. Based on interview on 02/11/13 at 2:59 p.m. with the Maintenance Supervisor, it was acknowledged the north and south smoke barrier walls on the second floor had unprotected openings which were not sealed with a fire rated material. 3.1-19(b)		Thank you for your time in reviewing our plan of correction and please call with any questions. Sincerely, Cathy S. Greene Executive Director North Woods Village	

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			The creation and submission of this plan of correction does not constitute an admission by this provider of any; conclusion set forth in the statement of deficiencies or of any violation of regulation. This provider respectfully request that the 2567 plan of correction be considered the letter of credible allegation and request a post **K025** It is the practice of this provider to ensure that the ceiling smoke barriers are protected to maintain one half hour fire resistance rating to meet LSC requirements. **What corrective actions will be accomplished for those residents**	

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			found to have been affected by the deficient practice? *Residents in the facility have the potential to be affected by the alleged deficient practice. *Area requiring a smoke barrier are protected to maintain the one half hour fire resistance rating have been assessed and appropriate areas have been repaired with fire caulk to meet the LSC requirement on 2-12-13 by Maintenance Supervisor. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** *Residents in the facility have the potential to be affected by the alleged deficient practice. *The facility has placed appropriate ceiling smoke barriers in identified area in second story north and south identified areas with fire caulk on 2-12-13 by Maintenance Supervisor **What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur?** *Identified areas have had appropriate ceiling smoke barriers repaired with fire caulk. *Reviewed other potential areas and have repaired these areas as needed with fire caulk to meet LSC Standards on 2-12-13 by Maintenance Supervisor **How will the corrective action be**	

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			monitored to ensure the deficient practice will not recur? *monthly preventive maintenance schedule and CQI "Life Safety Review" tool will be used weekly x 4, monthly x 3 and quarterly up to 6 months to monitor so deficient practice does not recur by Maintenance Director. *Maintenance Director is responsible for compliance, results will be reported to QA committee Completion Date: 3-13-13 certification review on or after 3-13-13.	

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 doors leading to hazardous areas on Service hall such as rooms with combustible items was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 4 residents in the Activity room adjacent to the Service hall as well as visitors and staff. Findings include: Based on observation on 02/11/13 at 12:55 p.m. with the Maintenance Supervisor, the Kitchen Storage room next to Laundry on Service hall contained thirty cardboard boxes inside the room which was greater than fifty square feet in size and it did not have a self closing device on the corridor door. Based on	K0029	K29 It is the practice of this provider to ensure that one hour fire rated construction ¾ fire rated doors have self closures to protect hazardous areas . **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** *Residents in the facility have the potential to be affected by the alleged deficient practice. *Dietary Area requiring self closure on door has had appropriate self closure installed on 2-13-13 by Maintenance Supervisor. **How will you identify other residents having the potential to**	03/13/2013

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	interview on 02/11/13 at 12:58 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned door leading into the Storage room containing combustible items was not equipped with a self closing device on the door. 3.1-19(b)		**be affected by the same deficient practice and what corrective action will be taken?** *All residents have the potential to be affected by the alleged deficient practice. *The facility has installed a self closure to door in dietary closet area identified on 2-13-13 by Maintenance Supervisor. **What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur?** *All hazardous area doors have been assessed to ensure all have appropriate self closures per Life Safety Code (LSC) by maintenance. Supervisor by 2-15-13 *Maintenance Supervisor will monitor with monthly preventive maintenance schedule. **How will the corrective action be monitored to ensure the deficient practice will not recur?** *monthly preventive maintenance	

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			schedule and CQI "Life Safety Review" tool will be used weekly x 4, monthly x 3 and quarterly up to 6 months to monitor so deficient practice does not recur. *Maintenance Director is responsible for compliance, results will be reported to QA committee Completion Date: 3-13-13 .	

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K0047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observations and interview, the facility failed to provide directional signs for 1 of 12 exit discharge means of egress. LSC 7.7.3 requires the exit discharge shall be arranged and marked to make clear the direction of egress to a public way. This deficient practice could affect 6 residents in Moving Forward dining room on Administrative hall, first floor including visitors and staff who may not be aware an exit exists at the east end of the Administrative hall. Findings include: Based on observation on 02/11/13 at 2:27 p.m. with the Maintenance Supervisor, there were no exit signs posted at the east end of the Administrative hall showing the primary exit discharge to the public way. Based on interview on 02/11/13 at 2:30 p.m. it was acknowledged by the Maintenance Supervisor, the primary exit to a public way from the Administrative hall was not obvious without exit signs posted. 3.1-19(b)	K0047	K47 It is the practice of this provider to ensure that exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** *Residents in the facility have the potential to be affected by the alleged deficient practice. *Exit sign in administrative area was installed 2-14-13 by Maintenance Supervisor. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** *Residents in the facility have the potential to be affected by the alleged deficient practice.	03/13/2013

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			*Exit sign in administrative area was installed 2-14-13 by Maintenance Supervisor. . **What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur.** *Exit sign in administrative area was installed 2-14-13 by Maintenance Supervisor. *All doors were checked by Maintenance Supervisor for appropriate exit signage. *Door signage will be monitored for per monthly Preventive Maintenance Schedule. **How will the corrective action be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place**? *monthly preventive maintenance schedule and CQI "Life Safety Review" tool will be used weekly x 4, monthly x 3 and quarterly up to 6 months to monitor so deficient	

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			practice does not recur. *Maintenance Director is responsible for compliance, results will be reported to QA committee Completion Date: 3-13-13	

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Edition, Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 5-6.3.4, "Minimum Distance between Sprinklers", states sprinklers shall be spaced not less than 6 feet on center. In addition, LSC 19.1.1.4.5 requires minor renovations, alterations, modernizations, or repairs shall not reduce life safety below the level that previously existed. This deficient practice could affect 5 residents in the adjacent Main dining room as well as staff or visitors near the kitchen. Findings include:	K0056	K056 It is the practice of this provider to ensure that complete automatic sprinkler system is installed in accordance with LSC standards. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** *Residents in the facility have the potential to be affected by the alleged deficient practice. *All areas identified have been reviewed and quotes for installation of appropriate sprinklers have been obtained and will be installed	03/13/2013

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	Based on observation on 02/11/13 at 12:40 p.m. with the Maintenance Supervisor, the west side of the Kitchen next to the freezer unit had two sprinkler heads located in the ceiling which were four feet apart. Based on interview on 02/11/13 at 12:42 p.m. with the Maintenance Supervisor, it was acknowledged the two sprinkler heads in question did not meet the six foot separation requirement. 3.1-19(b)		properly ASAP per PIPE sprinkler company. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** *Residents in the facility have the potential to be affected by the alleged deficient practice. *All areas identified have been reviewed and quotes for installation of appropriate sprinklers have been obtained and will be installed properly ASAP per PIPE sprinkler company. **What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur.** *All sprinklers have been checked to ensure proper footage between sprinkler heads per LSC standards by Maintenance Supervisor. *Will be monitored per monthly Preventive Maintenance Schedule. **How will the corrective action be monitored to ensure the deficient**	

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			practice will not recur i.e., what quality assurance program will be put into place? *monthly preventive maintenance schedule and CQI "Life Safety Review" tool will be used weekly x 4, monthly x 3 and quarterly up to 6 months to monitor so deficient practice does not recur. *Maintenance Director is responsible for compliance, results will be reported to QA committee Completion Date: 3-13-13	

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K0062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure 2 of 11 sprinkler heads observed in the Kitchen were free of corrosion. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect the 5 residents in the adjacent Main dining room as well as staff and visitors. Findings include: Based on observation on 02/11/13 at 12:30 p.m. with the Maintenance Supervisor, the two sprinkler heads located in the Dish room of the Kitchen were covered with corrosion around both the sprinkler apertures. Based on interview on 02/11/13 at 12:31 p.m. with the Maintenance Supervisor, it was confirmed the sprinkler heads located in the Kitchen dish room were corroded. 3.1-19(b) 2. Based on observation and interview,	K0062	K62 It is the practice of this provider to ensure that required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** *Residents in the facility have the potential to be affected by the alleged deficient practice. *All areas identified have been reviewed and quotes for installation of appropriate sprinklers have been obtained and will be installed properly ASAP per PIPE sprinkler company. *The sprinkler pipe with cable wire wrapped on it in Room #240 has had cable wire removed by Maintenance Supervisor **How will you identify other**	03/13/2013

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	155139	A. BUILDING 01 B. WING	02/11/2013

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	the facility failed to ensure 1 of 1 automatic sprinkler systems was maintained in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect 28 residents on second floor, east hall as well as visitors and staff. Findings include: Based on observation on 02/11/13 at 2:45 p.m. with the Maintenance Supervisor, a ten foot section of a two inch diameter sprinkler pipe had cable wire wrapped around the sprinkler pipe in resident room # 240. Based on interview on 02/11/13 at 2:48 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned sprinkler pipe in room # 240 had a cable wire wrapped around the pipe for support. 3.1-19(b)		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** *Residents in the facility have the potential to be affected by the alleged deficient practice. *All areas with sprinkler heads have been checked for proper operating condition by Maintenance Supervisor. *All sprinkler pipes have been checked for cable wire per Maintenance Supervisor. **What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur?** *All areas identified have been reviewed and quotes for installation of appropriate sprinklers have been obtained and will be installed properly ASAP per PIPE sprinkler company *All sprinkler pipes have been checked for cable wire per Maintenance Supervisor. *Will be monitored through preventive maintenance monthly check and quarterly fire alarm system check.	

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			How will the corrective action be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? *monthly preventive maintenance schedule and CQI "Life Safety Review" tool will be used weekly x 4, monthly x 3 and quarterly up to 6 months to monitor so deficient practice does not recur. *Maintenance Director is responsible for compliance, results will be reported to QA committee Completion Date: 3-13-13	

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K0104 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.			
	Based on observation and interview, the facility failed to ensure 1 of 9 smoke walls penetrated by ventilation ducts was provided with a smoke damper. LSC 101 section 8.3.5.1 states an approved damper designed to resist the passage of smoke shall be provided for each air transfer opening or duct penetration of a required smoke barrier. This deficient practice could affect 24 residents on north hall, second floor, as well as visitors and staff in the event of a fire emergency. Findings include: Based on observation on 02/11/13 at 3:07 p.m. with the Maintenance Supervisor, a smoke damper was not installed in a six inch diameter supply ventilation duct which penetrated the north smoke barrier wall on the second floor. Based on interview on 02/11/13 at 3:10 p.m. with the Maintenance Supervisor, it was acknowledged the north smoke barrier wall which was penetrated by ventilating ductwork was not protected with a smoke damper. 3.1-19(b)	K0104	K104 It is the practice of this provider to ensure that the penetrations of smoke barriers by ducts are protected in accordance with 8.3.6 to meet LSC requirements. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** *Residents in the facility have the potential to be affected by the alleged deficient practice. *Area requiring a smoke wall penetrated by ventilation ducts on second floor, the temporary ducts were removed, dry wall installed and repaired with fire caulk to meet the LSC requirement on 2-12-13 by Maintenance Supervisor. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** *Residents in the facility have the potential to be affected by the alleged deficient practice.	03/13/2013

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			*Area requiring a smoke wall penetrated by ventilation ducts on second floor, the temporary ducts were removed, dry wall installed and repaired with fire caulk to meet the LSC requirement on 2-12-13 by Maintenance Supervisor. * All other smoke walls checked to ensure to meet the LSC requirement on 2-12-13 by Maintenance Supervisor. **What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur?** *Area requiring a smoke wall penetrated by ventilation ducts on second floor, the temporary ducts were removed, dry wall installed and repaired with fire caulk to meet the LSC requirement on 2-12-13 by Maintenance Supervisor. * All other smoke walls checked to ensure to meet the LSC requirement on 2-12-13 by Maintenance Supervisor. *Will be monitored through preventive maintenance monthly check per Maintenance Supervisor	

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			How will the corrective action be monitored to ensure the deficient practice will not recur? *monthly preventive maintenance schedule and CQI "Life Safety Review" tool will be used weekly x 4, monthly x 3 and quarterly up to 6 months to monitor so deficient practice does not recur by Maintenance Director. *Maintenance Director is responsible for compliance, results will be reported to QA committee Completion Date: 3-13-13	

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K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms, where oxygen transfer occurs had a sign posted indicating oxygen transfer was occurring in the oxygen storage room located on the first floor, east hall. This deficient practice could affect 4 residents observed in the Moving Forward dining room, first floor as well as visitors and staff near the oxygen storage room. Findings include: Based on observation on 02/11/13 at 12:45 p.m. with the Maintenance Supervisor and Nurse # 1 who was in the oxygen storage room on East hall, first floor conducting a transfill of oxygen,	K0143	K143 It is the practice of this provider to ensure transferring oxygen is in an area posted with signs indicating that transferring is occurring . **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** *Residents in the facility have the potential to be affected by the alleged deficient practice. *Transferring oxygen sign was put in place immediately and inservice to staff that would transfer oxygen was given on 2-19-13 by Staff Development Coordinator.	03/13/2013

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	there was no sign posted on or near the oxygen storage room door indicating the transfer of oxygen was being conducted at this site. Based on interview on 02/11/13 at 12:47 p.m. with the Maintenance Supervisor and Nurse # 1, it was acknowledged they did not know posting a sign was required, or if the facility had one available. 3.1-19(b)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** *Residents in the facility have the potential to be affected by the alleged deficient practice. *Transferring oxygen sign was put in place immediately and inservice to staff that would transfer oxygen was given on 2-19-13 by Staff Development Coordinator. *Rounds will be completed daily x 2 weeks periodically thereafter for correct usage of sign, by Director of Nursing and/or designee **What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur?** *Identified fire alarm control panel area has had automatic smoke detector installed. *Transferring oxygen sign was put in place immediately and inservice to staff that would transfer oxygen was given on 2-19-13 by Staff Development Coordinator. *Rounds will be completed daily x 2	

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			weeks periodically thereafter for correct usage of sign, by Director of Nursing and/or designee **How will the corrective action be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *monthly preventive maintenance schedule and CQI "Life Safety Review" tool will be used weekly x 4, monthly x 3 and quarterly up to 6 months to monitor so deficient practice does not recur by Maintenance Director. *Maintenance Director is responsible for compliance, results will be reported to QA committee . Completion Date: 3-13-13	